Q1. I need clarification about the cost proposal/budget sections in both the FOCUS and Family Service Centers RFP. The question is will the provider have to have 25% matching of the costs? (i.e. if it costs $100,000 to run the program, does the agency have to have 25% of that? Please clarify. Will the provider be able to bill any other party like Medicaid in either RFPs?

R1. The requirement is 25% match as stated in the RFP. The match requirement is not new to the 2008 RFP, but was also required in 2006. In addition, Medicaid billing is not an option.

Q2. Page 16-17 Required staff and their qualifications: As long as the in-home workers qualify, is it acceptable to employ either master's or bachelor's level background?

R2. Program staff must meet the qualifications for persons performing in-home services and the requirement of the model selected by the Vendor.

Q3. Page 25: Service Delivery Approach: Is it acceptable to customize an RFP to propose services for more than one region?

a. What may be the advantages to composing one RFP for more than one region?
b. What may be the advantage to composing a different RFP for each region proposed?

R3. Vendors who intend to propose to serve more than one region, must specify the region(s) in their proposal. However, Vendor must submit only one (1) proposal.

Q4. Page 7: Project Overview**:** Is it allowable to exceed the number of allowed slots within a month as long the total slots for the year does not exceed?

R4. No.

Q5. Page 28: Budget: At what point does a provider bill for services?

a. Will the provider bill at the point of the accepted referral?

R5. Vendors may bill for entire month for referrals received prior to the 16th of the month. For referrals received after the 16th of the month, Vendors may only bill for half of a month.

Q6. Page 7: Project Overview: Using any region as an example, given that the family's assessment of needs will dictate the length of treatment within the required time span, what will be the total number of families expected to be served?

R6. A slot equals one family. An agency were awarded 18 slots, they would serve 18 families.

Q7. What are specific recommendations for under utilization of services by counties?

R7. Historically, this type of program has a waiting list.

Q8. Will programs be able to sustain budget projections to maintain needed staff during periods of intermittent or sporadic low referrals?

R8. **Providers will receive payment for actual services rendered. All contracts issued for this procurement will be a fixed rate contracts and not a cost reimbursement contracts.**

Q9. Should a provider(s) continue to experience low to no referrals after considerable efforts to increase services, will there be a negative impact or penalty to the provider?

R9. **Negative impact would be that the Vendor would receive no money if no families are being served.**

Q10. pg 28, 5.0 Budget: A state/local match equaling 25% is required, in previous years the Vendor has been asked to show the amount of match they could provide. Assume vendor is being asked to provide as much as they feel they can with no exact % required from local vendor?

R10. **See R1.**

Q11. pg. 43, Appendix F: Cost Reimbursement, RFP states that Audit costs can only be included with prior DHR approval, how is that to be obtained prior to submission of the application?

R11. **Assume approval for RFP process.**

Q12. pg 42/43, Appendix F Cost Reimbursement: Are copies of leases, comparable rent statements to be submitted with the application or just referenced as being on file in the vendor office?

R12. **Vendors may reference that completed forms are being maintained on file in their office.**

Q13. pg. 42/43 Appendix F Cost Reimbursement: How will we invoice for FO? Monthly allowable x # families on an invoice or actual expenditures on Appendix E form?

a. What documentation is required to be mailed in?
b. What will our FO In-Kind match percentage be?
c. Are mid-year budget amendments allowed to best utilize funds?
d. Are current equipment leases allowed? (Xerox copier, computers)

R13. **Vendors must invoice for the monthly rate times the number of families or the half rate times the number of families.**

a. Documentation will be discussed at contracting.
b. 25%.
c. Budget amendments are not part of the fixed rate contract.
d. Yes, cost must be factored into the fixed rate.

Q14. pg. 16 - 3.1 Program Specifications: Vendors must understand that all training of staff will be at their expense…, will Vendor be allowed to include monies for training in their budgets?

R14. Budgets may include any cost deemed necessary by the Vendor, but understand that the rate is a fixed rate and also capped at the maximum rate specified in the procurement document.

Q15. pg 16 - 3.1 Program Specifications: Could vendors participate in DHR trainings such as ACT, ISP, and Assessment in order to more effectively support open child welfare cases?

R15. No.

Q16. pg. 16, Referral Procedure: Vendors that reject more than 15% may have the slots reduced - it is understood that caseloads are to be increased according to this RFP but often cases are rejected due to having no vacancies. If caseloads are increased and ,no vacancies occur, will vendor be penalized?

R16. If a Vendor has no vacancies then refusing to accept a family is not considered a rejection.

Q17. pg, 24, References: Can local DHR Director be listed as a Reference and will he/she be allowed to write a letter of concurrence for the program?

R17. County DHR Directors should not be listed as a reference. Vendors should identify other community partnerships.

Q18. pg, 24, References: Are letters of reference required in the application or should we just include the information required in the RFP?

R18. References are required.

Q19. pg 25, Vendor Financial Stability, RFP states the auditor is to write a letter, what information should be included in the letter and is it to be direct to SDHR?

R19. The letters, which indicate errors or the absence of errors from accountants that accompany completed audits, are sufficient.

Q20. The RFP states that revisions can be made and will be posted on the Website, will SDHR show this Revision as such on the webpage?

R20. If applicable, revisions will be posted to the Department's web site at www.dhr.alabama.gov .

Q21. Can you give further explanation of the method of intervention and how that is to be developed? Two of the interventions previously mentioned (FFT and MST) are targeted for families with youth ages 10-18 and many of the families served have infants.

a. In developing a new/different model how will merit staff be integrated into the intervention if local DHR is not included in discussions?

R21. There are models that cover all types of families. You can use hybrids. Local DHR directs all activities in the ISP.

Q22. With sites that have merit and contract staff will the local DHR adhere to the intervention established and will the Vendor be responsible for training Merit staff?

R22. Yes.

Q23. Further clarification is needed concerning this RFP as it relates to sites that have Merit and Contract staff, are Merit staff aware of the modifications in programming, new stipulations in the RFP, etc.?

R23. All RFPs are made public and posted on the Department's website.

Q24. pg. 18, Aftercare 3.1.13: Will you provide further clarification on what this means, etc., is the 90 discharge period an allowable billing expense for the family?

a. Does follow-up with a family, count as far as the acceptable caseload numbers or it is above the expected caseload number? Any information on what this section is referring to will be appreciated.

R24. Aftercare is not part of the caseload. Aftercare is provided to discharged cases and discharged cases are not part of the case load.

Q25. pg.18 - Aftercare 3.1.13: If a family has been discharged from the program and in 4 months is re-referred to FOCUS, will we be able to charge for the services?

R25. Yes.

Q26. Section 1.0, Project Overview, pg. 7 – This section says that "FOCUS Programs will be required to provide…interventions…where removal of children from the home is imminent". Please detail the spectrum of risk to be dealt with in the RFP program, clarifying the level of risk?

R26. If local DHR feels that the children are at imminent risk.

Q27. Section 3.0, Description of Services, pg. 16 – This section says "The FOCUS worker shall work with no less than four (4) families at a time…". The minimum number is dependent on referrals from DHR. What if DHR has not referred sufficient clients for all FOCUS workers to maintain a minimum of four families? Would the Vendor be considered out of compliance?

R27. No.

Q28. Section 3.1.2, Referral Procedure, pg. 16 – If a program rejects a client solely because the program is at capacity, does that rejection count against the 15% rejection cap?

R28. See R16.

Q29. Section 3.1.3, Number of Families to be served, pg. 16 - For siblings placed in multiple placements requiring a FOCUS worker to travel more extensively and increase visitations, will the Vendor be allowed to count this as more than 1 slot? If so, would the additional children be counted as .5 slots, or would it be considered a filled slot?

R29. One slot equals one family.

Q30. Section 3.1.4, Required Staff and their Qualifications, pg. 17 – Would a criminal justice degree be appropriate for a Family Support Worker?

R30. No.

Q31. Section 3.1.4, Required Staff and their Qualifications, pg. 17, and Section 3.3.1, item k, pg. 21 – The RFP refers to Therapists, including review by DHR of therapist reports. However, there are no clear guidelines regarding the role of therapists in the FOCUS program. Please outline the role of therapists, and what reports DHR would expect to receive and review.

R31. Therapists used by the family may or may not be part of the provider staff. The role of the therapist is to work on goals outlined in the ISP and DHR would want to review reports to look at goal completion and concentrate on any of the mental health issues or observances of the therapist.

Q32. Section 3.1.4, Required Staff and their Qualifications, pg. 17 – This RFP does not reference clerical staff. Is that included in this RFP?

R32. See R13d.

Q33. Section 3.1.13, Aftercare, pg. 18 – Please define "aftercare" and detail DHR's specific expectations regarding Vendor provision of aftercare, including timeframe, types of care and intensity?

R33. Aftercare is a 90 day period, after discharge, where the Vendor follows up with the family and deals with any crises that arise.

Q34. Section 3.1.13, Aftercare, pg. 18 - If a case has to be reopened during the aftercare portion of the FOCUS intervention, under what circumstances would that be considered a continuation of the previous case?

a. Under what circumstances would it be a new case?
b. If it is a new referral and intake, how should the Vendor approach it?
c. Will the Vendor be reimbursed at the monthly rate for the newly opened intervention?

R34. Cases are not reopened in aftercare.

a. If something new emerges then a new referral can be made by local DHR with State DHR approval.
b. Like a new referral.
c. Vendors will be reimbursed based on date of referral.

Q35. Section 3.1.14, Tracking, pg. 18 – What is the protocol for indicating that the family is unreachable for tracking purposes?

a. If a family has been closed to FOCUS service and the whereabouts of the family is unknown to both the program Vendor and DHR staff, what are the program's tracking obligations at 12 and 24 months?

R35. Vendors should attempt to contact family, if they are unsuccessful then they should contact DHR to see if there is an open case, if not then Vendors should report the family as unknown to State DHR.

Q36. Section 3.2 item I, Core Services, pg. 19 – Is the reporting form referenced here the same one currently used by state DHR?

R36. Contract issues will be discussed after Vendors have been notified of awards.

Q37. Section 3.3.2 item E, Roles of Workers, pg. 21 - The RFP states "The IIHS agency is responsible for recruiting candidates for the various positions that are part of the contract and for coordinating with DHR on the suitability of the various candidates." Please clarify what DHR's role and expectations for "coordinating" are?

R37. State DHR needs to be advised of people being hired for the program and assured of all necessary clearances and background checks.

Q38. Section 3.3.2 G, Roles of IIHS Workers, pg. 21 – Who is responsible for writing the CFA? If DHR does not complete it, are FOCUS staff required to write it? Please define "may coordinate", and who is responsible for writing the CFA.

R38. Local DHR.

Q39. Section 3.3.2 item I, Roles of Workers, pg. 21 - The RFP mentions school involvement. If the children are not enrolled in school, should the worker also seek input from daycare facilities? If the child (ren) are doing well in school, is there a need to include direct Information from the school system in the monthly report to DHR?

R39. Yes. Yes.

Q40. Section 3.3.2 item P, Roles of Workers, pg. 21 - What are the expectations of a behavioral management plan? Please define this and provide clarity on the differentiating roles between a DHR worker and an IIHS worker.

R40. DHR will be responsible for completing the plan with assistance from Vendor.

Q41. Section 4.2.5.1.2, References, pg. 24 – References have been omitted from recent RFPs. Are they required for this RFP?

a. If so, may Vendors use local DHR staff as references?

R41. See R18.

Q42. Section 5.0, Budget, pg. 28 – Will the state continue their match efforts to draw down federal dollars?

a. Does providing a local match improve the Vendor's budget score?
b. If so, is the improvement proportional to the match amount provided?

R42. 75% of the program funding is federal and the 25% match is an RFP requirement.

Q43. Section 5.0, Budget, pg. 28 – Will the $1520 a month rate be adjusted when payments are made to the provider from sources other than DHR, including in-kind? Clarify the impact of in-kind contributions on payments to the Vendor from DHR.

R43. $1520 is the fixed monthly rate.

Q44. Section 5.0, Budget, pg. 28 – In previous Family Options RFPs, family preservation money and family incentive money were included in the budget. However, this FOCUS RFP does not include either. Will there be family preservation funds and family incentive funds available to the Vendor from DHR, under this contract?

R44. This is a fixed rate contract – funding expenditure by type is a cost allocation activity for state DHR Finance.

Q45. Section 1; Project Overview and Instructions, page 7 Does DHR have particular nationally-recognized, evidence-based models in mind when referencing the need to indicate such a model in the proposals?

R45. No.

Q46. Section 3, Scope of Project, page 18 If a provider has a successful program that has been proven through more than a decade of data to ensure long-term positive outcomes for youth, but the average LOS for the service exceeds the length of intervention in the RFP, does the provider have the flexibility to identify their own LOS?

R46. No, extensions of LOS must have state office approval.

Q47. Section 3, Scope of Project, page 20 Can DHR provide clarification on the overlap of the terms FOCUS worker and Intensive In-Home Services worker? In Sections 3.2-3.3, these terms seemed to be used interchangeably.

R47. They are the same.

Q48. Section 5; Cost Proposal, page 28 The RFP states that a fixed rate of $1,520 is the maximum reimbursement rate per family per month. Is the local/state match of 25% included in the stated maximum amount or is it added to this maximum amount allowing for more money to be spent per family per month?

R48. Yes. It includes the state match.

Q49. Under the previous Family Preservation and Reunification services contract, some vendors were providing Assessment Only and Reunification Assessment services. Will vendors be expected to continue these services to counties?

a. If not, will State DHR notify counties of changes to the contract in advance, and vendors be notified when to stop accepting these referrals?

R49. Vendors will not be required to do assessments.

a. State DHR will notify counties not to make assessment referrals after August 01, 2008.

Q50. Page 16, 3.1.1 *Siblings groups that are in more than one placement may be served by FOCUS, as well.* Would each placement family be considered a separate slot, since the children would be in different homes?

a. And what about the birth family? (For example, there are three identified children, one in foster care, two in a home with a relative and a birth mother, whom the vendor is working with toward reunification).
b. Would this be considered three slots?

R50. See R29.

Q51. Page 16 -17, 3.1 4 *Supervisors/ Family Support Workers must possess a degree in the field of social work, psychology, human and child development, counseling, or sociology from a college or university accredited by one of the six regional etc.* What about bachelors/masters degrees in the following areas: Criminal Justice, Education, Journalism and Rehabilitation?

a. And can a certain amount of experience supplement the educational requirements for required fields?

R51. No. No.

Q52. Page 19, 3.2 A*., C., D., G., I.,* All of services listed in these categories are services required for Medicaid Rehab. Does the program follow Medicaid Rehab requirements regarding documentation?

R52. Medicaid Rehab billing is not a requirement but documentation must be detailed and defensible.

Q53. Page 28 5.0 *Vendors will be compensated for all eligible expenditures resulting from a contract for the services described in this procurement at a fixed rate of no more than $1,520 per month for a family.*

a. How will vendors be reimbursed for families that do not receive services for the entire month?
b. Will this be pro-rated?

R53. See R5.

Q54. Page 28 5.0 *A state/local match equaling 25% of the combined federal and state/local funding is required to secure the federal funds.* Will vendors be expected to provide more that 25% of the matching funds in fiscal year 2009?

R54. See R1.

Q55. Page 30 CHARGE *BACKS: The Alabama Department of Human Resources and Medicaid will deduct federal charge backs from future payments.* Please specify what this means and if vendors will have state and federal Medicaid audits. How will charge backs be determined for vendors that are not billing Medicaid?

R55. There should be audits by State DHR for contract compliance. There should not be any Medicaid audits.

Q56. SECTION 1: PROJECT OVERVIEW & INSTRUCTIONS, p. 7: Will all slots allotted for a region be granted to a single provider or divided between multiple providers?

R56. The Department will base its decision upon responses received. If no single vendor offers to provide the prescribed services at an acceptable rate, then the Department will consider multiple vendors.

Q57. EJECT/REJECT POLICIES: 3.1.11, p. 18 *It is expected that no more than 15% of appropriate referrals will be rejected by a vendor.* Does this apply when a provider is currently serving all allotted slots?

R57. See R16.

Q58. AFTERCARE: 3.1.13, p.18 *FOCUS Programs should provide no less than 90 days of aftercare.* Does the aftercare component require face-to-face contact with families?

a. Are aftercare cases included in the caseload count?
b. Are aftercare costs reflected in the $1520 cost per consumer?
c. What are the expectations for crisis intervention services at post-discharge?

R58.

a. No.
b. Aftercare is not billable.
c. That should be part of your response.

Q59. CORE SERVICES, 3.2, p. 19: *Conduct two or more (as needed) in-home face-to-face contacts per week with the family…* 3.2 C:

a. Can the number of face-to-face contacts decrease towards the end of services according to a family's progress and the ISP team?
b. 3.2. J., p. 20: Please define "expertise" related to IIHS providers maintaining staff having expertise in developing behavior management plans.
c. 3.2. K., p. 20: Please clarify if only DHR will develop safety plans.

R59.

a. As needed and ISP directed.
b. Have experience or will receive training.
c. See R40.

Q60. ROLES OF IIHS WORKERS 3.3.2.E., p. 21: Does "coordinating with DHR on the suitability of candidates" mean completing CAN clearances for new hire candidates.

a. 3.3.2. Q., p. 22 Question: What is the definition of a crisis plan?
b. 3.3.2. S., p. 22 Question: When and how will DHR make pertinent policies (procedures, regulations) available to the providers?

R60.

a. A crisis plan should be developed by the Vendor in conjunction with the ISP team to address actions that will be taken in the event of a crisis with the child(ren).
b. Pertinent policies (procedures, regulations) are included in the RFP document.

Q61. BUDGET, 5.0, p. 28 Is the monthly fee prorated? For example, if the family drops out after 2 weeks, does the provider get paid for that service? If the family receives services for 6 weeks, is the provider paid for the additional 2 weeks?

R61. See R5.

Q62. Section 4.2.5.1.2, Page 24, References – Will Reference be waived for this RFP as they been in the last couple of RFPs issued?

R62. See R18.

Q63. Section 5.0, Page 28, Budget – Please further explain the 25 % state/local match equaling 25 % of the combine federal and state/local funding?

R63. See R1.

Q64. Appendix F, Page 40, Budget – Number 9 and 10 – Please provide examples of how line 9 and 10 should be completed?

R64. Refer to the instructions, included in the RFP for completing the Cost Reimbursement Budget.

Q65. Appendix F – Cost Reimbursement Budget – Should the rate reflect a daily or monthly rate?

R65. This procurement offers a monthly fixed rate.

Q66. Appendix F – Is there a maximum indirect cost Rate?

R66. The budget shows the breakdown of total cost but, remember the rate is a fixed rate.

Q67. Appendix F- Indirect Cost – Please give example of how services such as Human Resources, Payroll, Information Services ... should be documented?

R67. See R66.

Q68. Section 3.1.5, Page 17, Supervisor/Staff Ratio – What is the required ratio of Supervisors to Therapists?

R68. Only family care workers have ratio to supervisors.

Q69. Section 1.0, Page 7, Project Overview – Is a provider required to provide services to a whole region or can they serve specific counties within a region?

R69. Whole region.

Q70 Will providers be required to incorporate a therapist/counselor position into the new program?

R70. No.

Q71. Please clarify the qualifications of the therapist; i.e. must they be licensed or is the appropriate Master's degree and 5 years of experience acceptable?

R71. Meet Medicaid requirements for Therapist.

Q72. Why are the supervisory qualifications so liberal?
R72. Requirements came out of the Continuum Committee recommendations.

Q73. The RFP indicates that "…no more than 15% of appropriate referrals will be rejected by a vendor". If the provider is at its maximum of 4-6 families per worker, why – how – and will the provider be penalized?

R73. See R16.

Q74 Would referrals to prevent disruptions in foster homes be appropriate?

R74. No.

Q75. Please clarify the expectation for the provision of Aftercare? This section requires that providers describe crisis intervention services that will be provided to families both during the intervention and post-discharge.
a. How does one provide "Aftercare" once the case is closed?
b. Since this is an area that should be developed in each family's ISP, should this be addressed in general terms in our proposals?

R75. The aftercare plan is part of the RFP response.

Q76. Please designate to providers what the SDHR expects providers to track and how often over the 24-month tracking period, i.e. at what intervals?

R76. See R35.

Q77. Will a report form be developed for providers to utilize in completing the monthly report for each family?

R77. The general format will be provided after notification of awards.

Q78. Several different time-frames are mentioned for providers to make initial contact with families, i.e. "within 24 hours"; "within 48 hours or sooner if needed"; and "must not exceed 4 working days from the date of admission". Please clarify?

R778 24 hours refer to an emergency referral and the other to a standard referral – within 48 hours is preferred but not to exceed 4 working days.

Q79. Please explain 3.3.2-Roles of IIHS Workers- G?

R79. To share case specific information with DHR so that DHR can complete the CFA.

Q80. How does SDHR expect IIHS workers to reasonably and effectively manage casework for up to 6 families while providing 2 home visits and providing skill building sessions each week AND travel in 6 or 7 different counties?

R80. Vendors must make case allocation decisions with these requirements in mind. Only Vendors that think they can meet or exceed the expectations should respond to this procurement.

Q81. There is a discrepancy regarding the Referral Procedure (Section 3.1.2) as follows: County DHR employees will make verbal referrals during regularly scheduled office hours and FOCUS staff must be accessible to take referrals during all non-office hours. Please explain how the procedure is to be followed?

R81. See R77.

Q82. There is confusion regarding the promptness of response to referrals in Section 3.1.6. It states FOCUS staff are required to contact the family face to face within 24 hours and if the FOCUS staff is unable to make initial contact to notify the DHR worker. In section 3.3.1 D, it states the DHR worker will contact the family to schedule a face to face in-home initial visit and introduction of the IIHS staff within 48 hours of admission. Which procedure are we to follow?

R82. See R77.

Q83. This question concerns the ISP requirements. Section 3.1.6 states the "FOCUS Provider should request an ISP prior to initiating services to gain a clear understanding of the desired outcomes expected by the Department." In section 3.2 of Core Services, it states that all treatment plans should be based on the goals established in the ISP. Section 3.3.1 under DHR roles A states DHR will be responsible for coordinating and facilitating the ISP and distribution of the document within 10 working days. Section 3.3.2 states IIHS worker is responsible for all assigned tasks in the ISP and must actively participate in the ISP. Therefore, is it saying there should be an ISP when the services begin to meet the requirements of the Core Services, DHR and IIHS roles? Whose job is it to initiate the ISP?

R83. There should be an ISP when services begin. DHR should initiate but the Vendor should also be able to require an ISP at anytime.

Q84. Section 3.1.7 Location of Service Provision mentions barriers in delivering the services to the family. What constitutes as a barrier and at what point do the "barriers" lead to termination of services?

R84. This issue will have to be reviewed on an individual basis and will require State DHR concurrence.

Q85. Please clarify what allows DHR to request an extension (what is the definition of not fully stabilized) and how long does an extension entail. What is the course of action if DHR and FOCUS do not agree upon an extension?

R85. See R46.

Q86. Is FOCUS responsible for Aftercare of a family or is this service referred to another community agency?

a. What if there is not an aftercare program in the county in which the family is being served?

b. Is FOCUS required to provide a type of Case Management or is the family referred back to DHR for supportive services that meet the qualifications of aftercare?

R86. FOCUS must provide aftercare and case management.

Q87. Section 3.2 of Core Services G states that FOCUS will supervise family visitation. Please clarify what "supervising" entails?

R87. Supervision includes being at the visitation, observing the interaction/visitation, providing feedback on the visitation to the family and DHR.

Q88. Section K under Core Services indicates we will participate in the development of the Safety Plan as needed. Does this mean not every case will have a safety plan? Cases will only have safety plans as indicated by DHR?

R88. Cases will have safety plans if the ISP team feels that safety is an issue.

Q89. Section 3.3.2 E states that IIHS is responsible for coordinating with DHR on the suitability of various candidates. Please explain and clarify?

R89. Vendors must notify the Department of its hiring decisions and must ensure that required checks and clearances have been obtained.

Q90. Section 3.1.13 AFTERCARE Please clarify the department's expectations regarding how aftercare services will be provided in light of the caseload ratios required in the intervention phase. Will additional staff be allowed that focus solely on aftercare services?

R90. Vendors must decide, the Department does not pay for aftercare.

Q91. PROJECT OVERVIEW pg.7

"Vendors will not be required to use a prescribed specific model identified by the Department in the provision of services but must indicate in their proposals what nationally recognized, evidence-based model will be used as a basis for service delivery."

Both the MST and the FFT models will require several months of training to become certified; may we proceed with a modified HomeBuilders model as we transition to a different model such as MST or FFT?

R91. See R21.

Q92. DESCRIPTION OF SERVICES pg. 16

"The FOCUS worker shall work with no less than four (4) families at a time and no more than six (6)."

We have seven (7) specialists; carrying a case load of a minimum of 4 families would require 28 slots. In order to meet the minimum we would need more slots than the RFP allows, is this possible?

R92. No.

Q93. 3.1.13 AFTERCARE pg. 18

"Each proposal should present clear, specific services that will provided to children and families once they have been discharged from the program. These aftercare services should be described as to type, frequency and duration. Each proposal should also describe crisis intervention services that will be provided during a family's tenure in the program, as well as post-discharge. FOCUS Programs should provide no less than 90 days of aftercare."

Since FOCUS programs must provide 90 days of aftercare, does that mean that we may count those families in our billable slots, even though it is post-discharge?

R93. See R24.

Q94. 3.2 CORE SERVICES pg. 19

A. *"…Copies of the intake evaluation or comprehensive family assessment, with adequate information for intake evaluation purposes, and an ISP must be provided to IIHS agencies within 10 days. DHR staff is required to complete and update regularly CFA's on all families referred for IIHS incorporating the information obtained by the IIHS agency into the document."*

What is the procedure if an ISP or CFA is not provided in a timely manner?

R94. Email the information to SDHR for follow up.

Q95. 3.3.1 DHR ROLES pg. 20

D. "*The DHR worker will confirm with the family the acceptance of the services deemed necessary for the family. The DHR worker will contact the family to schedule a face to face in-home initial visit and introduction of the IIHS staff to the family within 48 hours (or sooner if needed) of admission. The initial visit must occur as soon as possible but must not exceed 4 working days from the date of admission. During the initial visit responsibilities and roles will be discussed."*

Does this conflict with the 24 hr. contact as required in **3.1.6 Promptness of response to Referrals**?

R95. A response within 24 hours is required in emergency situations.

Q96. 3.3.2 ROLES OF IIHS WORKERS pg. 21

C. *"The IIHS worker/staff is responsible for meeting the requirements listed in the core services, including by not limited to maintaining a no-reject/no-eject policy for families who meet the program criteria."*

Section **3.1.11** Eject/reject policy states that no more than 15% will be rejected, does this conflict with this section?

H. *"IIHS staff is required to be available to the families 24 hours per day 7 days per week and should be available to provide crisis intervention as needed."*

What is DHR's expectation or definition of *crisis intervention*?

R96. It is expected no family referred and meeting the criteria will be rejected. No more than 15% will be allowed under the contract.

Q97. 4.2.5.1.2 REFERENCES pg. 24

"The proposing Vendor must provide a minimum of three (3) references for which it has performed similar services".

Can these references be from County DHR staff?

R97. See R17.

Q98. 5.0 BUDGET pg. 28

*"A **state/local match equaling 25% of the combined federal and state/local funding** is required to secure the federal funds. Cash, goods, or services, including third party in-kind contributions, are allowable sources of match. Please identify any local matching funds your agency can make available or has secured for this project."*

In the past we have been notified of the state's share of the 25% match, will the State make

R98. 25% match is the Vendor's responsibility.